TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN OTHROPEDIC GROUP, LLP

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-2250-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with decision for the fact that code 22845 has been cancelled and there is no bundling conflicts so codes 22830 and 22845 should be reprocess for payment."

Amount in Dispute: $3,225.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor initially billed codes 22551, 22855, 22830, 22845, 22851, and 20936 for cervical fusion surgery with removal of old hardware and insertion of new. Texas Mutual received the bill 8/11/16. Texas Mutual paid 22551, 22855, and 22851 then denied payment of 22830 and 22845 based on NCCI Edits. The Edits indicate both 22830 and 22845 are comprehended by code 22855 and that both codes can be modified. However, the requestor did not append modifiers to either code. (Attachment 1) Texas Mutual received a new bill from the requestor on 10/27/16. This bill listed codes 22551, 22851, 20936, 22830, and 22845. Code 22855 is not listed on this bill, which the requestor explains by stating the code has been cancelled and now codes 22830 and 22845 can be paid. Texas Mutual declined an additional payment stating the benefits for these codes were included in the payment allowance for another service/procedure already adjudicated, i.e. the previous payments made for the previous bill submitted by the requestor. (Attachment 2) Texas Mutual's initial payment was based substantially on the operative report and modification by the NCCI Edits. The importance of the operative report is that it substantiated the removal of old hardware, which the requestor billed for with code 22855. The requestor states it cancelled code 22855 and now expects payment for codes 22845 and 22830. The operative report remains unchanged. That portion of the report detailing removal of old hardware has not been cancelled. The 'cancellation' of code 22855 and ignoring the operative report in order to have two other codes paid is not an appropriate remedy. The appropriate remedy was the application of a modifier to codes 22845 and 22830. The requestor elected not to do that."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2016	CPT Code 22845 Insert Spine Fixation Device	$1,535.43	$0.00

	CPT Code 22830 Exploration of spinal fusion	$1,689.95	$0.00
TOTAL		$3,225.38	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 provides definitions for the medical bill and auditing processes.
3. 28 Texas Administrative Code §133.250 sets out the procedures for submitting a bill for reconsideration and the insurance carrier's audit process.
4. 28 Texas Administrative Code §133.240 provides procedure for the medical bill and auditing processes.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
6. The services in dispute were reduced/denied by the respondent with the following reason code:
    - CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements.
    - 435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
    - CAC-18-Exact duplicate claim/service.
    - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - 217-The value of this procedure is included in the value of another procedure performed on this date.
    - 715-Service previously billed with different/incorrect codes, provider, claim, etc. processed as correction only-no addtnl payment.
    - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
    - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

1. Is the requestor due reimbursement for codes 22830 and 22845 rendered on August 1, 2016?
2. Is the respondent's position that final action was taken on the August 11, 2016 bill supported?
3. Did the requestor comply with the reconsideration process outlined in 28 Texas Administrative Code §133.250?
4. Can the requestor cancel a code that the insurance carrier has taken final action on?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for codes 22830 and 22845 based upon reason codes ""CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements," and "435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure."

   The respondent contends that reimbursement is not due because "The requestor initially billed codes 22551, 22855, 22830, 22845, 22851, and 20936… Texas Mutual paid 22551, 22855, and 22851 then denied payment of 22830 and 22845 based on NCCI Edits…Texas Mutual received a new bill from the requestor on 10/27/16. This bill listed codes 22551, 22851, 20936, 22830, and 22845. Code 22855 is not listed on this bill, which the requestor explains by stating the code has been cancelled and now codes 22830 and 22845 can be paid."

The requestor states in the reconsideration letter that "We disagree with decision for the fact that code 22845 [sic] has been cancelled and there is no bundling conflicts so codes 22830 and 22845 should be reprocess for payment.

The applicable rule to determine if the respondent's denial of payment for codes 22830 and 22845 is found at 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

Per CCI edits, codes 22830 and 22845 are a component of code 22855, a modifier is allowed to differentiate the service. A review of the submitted billing finds that the requestor did not append a modifier to codes 22830 and 22845. The division finds the respondent's denial of payment based upon "CAC-236" and "435" is supported.

Furthermore, The National Correct Coding Initiative Policy Manual For Medicare Services, effective January 1, 2016, Chapter IV, section (H)(9) states, "General Policy Statements: Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59." Based upon the submitted operative report, code 22855 and 22830 were performed in the same surgical field; therefore, per Medicare policy code 22830 should not have been billed.

The Division concludes that the requestor is not entitled to reimbursement for codes 22830 and 22845.

2. The respondent wrote "Texas Mutual had taken final action on the bill received 8/11/16. Rule 133.240(k) states 'Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to the insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title.' When Texas Mutual issued payment of the requestor's bill and the requestor did not request reconsideration of that payment as provided in Rule 133.250 but instead submitted a new bill, Texas Mutual's payment then became final."

   28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill…"

   28 Texas Administrative Code §133.2(6) defines "Final action on a medical bill--(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

   28 Texas Administrative Code §133.240(e) states "The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form."

   The respondent submitted a copy of an explanation of benefits dated September 12, 2016 that supports payment of codes 22551, 22855 and 22851. Codes 22830 and 22845 were denied based upon reason codes "CAC-236," and "435."

   The division finds that the respondent took final action on the complete bill dated August 11, 2016 in accordance with 28 Texas Administrative Code §133.2(6) and §133.240(a) and (e).

3. The respondent states "The importance of the operative report is that it substantiated the removal of old hardware, which the requestor billed with code 22855. The requestor states it cancelled code 22855 and now expects payment for codes 22845 and 22830. The operative report remains unchanged. That portion of the report detailing removal of old hardware has not been cancelled. The 'cancellation' of code 22855 and ignoring the operative report in order to have two other codes paid is not an appropriate remedy."

   A review of the submitted bills finds:

   • The requestor's original bill dated August 11, 2016 lists codes: 22551, 22855, 22830, 22845, 22851, and 20936.

   • The requestor's bill dated October 24, 2016 lists codes: 22551, 22851, 20936, 22830 and 22845.

28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."

Because the requestor excluded code 22855 from this bill, the division finds that the requestor did not comply with 28 Texas Administrative Code §133.250(d)(1) since it did not include the same billing codes or dollar amount as the original bill.

28 Texas Administrative Code §133.250(a) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action."

No documentation was submitted that the requestor requested reconsideration for the original bill dated August 11, 2016.

4. The requestor states in the reconsideration letter that "We disagree with decision for the fact that code 22845 [sic] has been cancelled and there is no bundling conflicts so codes 22830 and 22845 should be reprocess for payment.

   The October 24, 2016 bill was submitted to the insurance carrier twice. The explanation of benefits indicate that the respondent maintained the denial of payment for codes 22830 and 22845 based upon "715-Service previously billed with different/incorrect codes, provider, claim, etc. processed as correction only-no addtnl payment."

   The requestor did not submit any documentation that a refund of payment for code 22855 was made; therefore, the allowance of code 22830 and 22845 is still included in the allowance of code 22855. The provider did not support position that the statute allows for a healthcare provider to be paid for a service, then cancel the service, in order to receive payment for bundled services. The division finds the requestor's position is not supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		04/25/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.